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Harvard Medical Alumni Bulletin

Volume 25, Number 3

April, 1951

ALUMNI DAY

Friday, May 25, 1951

HARVARD MEDICAL ALUMNI ASSOCIATION HARVARD MEDICAL SCHOOL

Registration in the Faculty Room — The Medical School — All Day

Program

Morning — No formal programs have been planned, but all alumni are welcome to attend operations and rounds at the following hospitals:

Beth Israel, Boston City, Children's Medical Center, Massachusetts General and Peter Bent Brigham.

12:30 p.m. — **BUFFET LUNCHEON** — Medical School Quadrangle

2 - 4 p.m. — **MEDICAL AND SURGICAL SYMPOSIA** — Amphitheatres B and C, The Medical School

MEDICAL

William B. Castle, Chairman
Herrman L. Blumgart
Derek E. Denny-Brown
Samuel A. Levine
J. Howard Means
George W. Thorn
George B. Wislocki

SURGICAL

Robert E. Gross, Chairman
Edward D. Churchill
Sidney Farber
Francis D. Moore
Merrill C. Sosman
John Homans
Grantley W. Taylor

(Subjects to be announced later.)

The Alumni Day program has been primarily planned for members of reuniting classes, who will have priority in attendance at the luncheon and lectures. Space permitting, all other alumni will of course be welcome at the day's events.

CLASS DAY EXERCISES

CLASS OF 1951

Saturday, May 26, 1951

HARVARD MEDICAL SCHOOL
HARVARD MEDICAL ALUMNI ASSOCIATION

Program

Class Day Exercises — The Medical School

Open House — The Medical School Laboratories

Buffet Luncheon — Medical School Quadrangle

The Medical School and the Class of 1951 extend a cordial invitation to all alumni and members of their families to attend the Class Day Exercises.

HARVARD MEDICAL ALUMNI ASSOCIATION

REUNION DINNERS — 1951

- 1901 — Harvard Club of Boston — Friday, May 25
 - 1906 — Harvard Club of Boston — Friday, May 25
 - 1911 — Harvard Club of Boston — Friday, May 25
 - 1916 — Harvard Club of Boston — Friday, May 25
 - 1921 — Hotel Continental, Cambridge — Friday, May 25
 - 1926 — Harvard Club of Boston — Friday, May 25
 - 1931 — Harvard Club of Boston — Friday, May 25
 - 1936 — Harvard Club of Boston — Friday, May 25
 - 1941 — Harvard Club of Boston — Saturday, May 26
 - 1946 — Harvard Club of Boston — Saturday, May 26
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J. Englebert Dunphy, '33, Editor; Thomas B. Quigley, '33, Richard Warren, '34, Associate Editors; Joseph Garland, '19, Wyman Richardson, '23, Editorial Board; Joseph S. Lichty, '33, Business Manager; Mrs. K. B. Wilson, Assistant to the Editor. 25 Shattuck Street, Boston 15, Massachusetts.

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Asclepius in Arms

WILLIAM DOCK, M.D.



When the mythical healers Chiron and Asclepius went to the wars, they went as fighting men. Chiron died of his wounds. Homer describes Eurypylos, wounded before Troy, being cared for by the mighty warrior Patroclus. For 2,000 years of recorded history the medical and surgical needs of fighting men were met by their

own rude skill, or that of camp-followers—cooks, barbers and prostitutes. Physicians might attend the great men and their immediate attendants. At various times these physicians were slaves, free men serving for fees, or priests. After the Renaissance, a few were learned men like Ambroise Paré, the friend of four kings of France and of the Huguenot nobles massacred on St. Bartholomew's Day.

Physicians who went to the war in search of patients held no military rank, and worked for fees in war as in peace. For warriors who had the price, there was free choice of physicians, even on the battle field. Foot soldiers who were peppered received no free surgical care and no pensions. As Falstaff pointed out, they "could beg through the town's end during life."

The Great Navigations and the Colonial Wars created an urgent need for doctors to serve with fleets or regiments, but this was met only by adventurous volunteers for a cruise or a campaign. Napoleon's chief medical advisor, Corvisart, and his surgeon general, Baron Larrey, always had large civilian practices when not in the field, and the military surgeon first emerges in the Prussian army. To provide such surgeons the excellent army medical school in Berlin was established. This permitted

While reminiscing about Oliver Wendell Holmes, Charles W. Eliot once said that the famous Autocrat of the Breakfast Table did not occupy a chair at the Harvard Medical School, he filled a bench. One might make a similar remark about William Dock. Born in Ann Arbor, Michigan, the son of George Dock, a celebrated American physician, he had his medical schooling at Rush Medical School and then spent two years or so at the Peter Bent Brigham Hospital. From there he studied in Vienna and later joined the faculty of Stanford University, where he became professor of pathology. His versatility was so apparent that when the chairs of anatomy and physiology became vacant his name was considered. From California he went east to take the post of professor of pathology at Cornell. As he was interested in clinical medicine throughout this time, it is not surprising that he returned to the professorship of medi-

cine, for a while in California and for the last several years at Long Island Medical College. His medical interests are so universal that hardly a field has not felt the imprint of his original and penetrating mind. Publications on pulmonary tuberculosis, primary anemia, renal physiology, heart sounds, the mechanism of heart failure and coronary sclerosis, the use of cation exchange resins, the simplification of ballistocardiographic apparatus are only a few of his many fundamental contributions to medicine. Less is known about his interest in military medicine and of the fact that he received the Croix de Guerre for his service with the French Army in the first World War.

The BULLETIN is privileged to publish this entertaining and penetrating analysis of military medicine which was originally delivered as the address at the annual midwinter dinner of the Aesculapian Club.

impecunious sons of good families to get all of their medical training. A distinguished alumnus was Hermann von Helmholtz, discoverer of the ophthalmoscope and of the law of conservation of energy. The American Government has never made any contribution to educating doctors for the military, or for any other service. The Army Medical School gives only graduate courses like those of the other service schools and the War College.

In the United States, army and navy surgeons maintained civilian practices for many decades after the Revolution. Also, even as late as our Civil War, the soldier had the right, so dear to many physicians, of selecting and paying his own doctor. Walt Whitman, in Washington, described the medical hyenas who preyed on soldiers from the Army of the Potomac, with their dysenteries and their septic wounds. Doubtless, some soldiers succeeded in getting competent private physicians or surgeons, but the odds were against them.

A healthy reorganization of our Army Medical Service was effected in 1820 by Joseph Lovell, who became Surgeon General at the age of 29. This attracted from civilian practice able men like William Beaumont, whose classical studies on gastric physiology are familiar to all. It may be mentioned that his patient, St. Martin, was a fur trapper and not one of his military charges, for Beaumont continued to serve civilians and presumably accepted fees from them. Even when military medicine was lost to free enterprise and became a salaried bureaucracy, military surgeons in distant outposts, often without official encouragement, still showed skill in investigation. Laveran in his French Colonial army post pursued the studies which led him to discover the plasmodia of malaria; Ross, a British Army surgeon, demonstrated its transmission by mosquitoes, and in our army Walter Reed made his classical observations on transmission of yellow fever.

Military surgeons have made few contributions to the care of burns and wounds. During the Crusades, Hugo de Lucca

brought clean surgery and healing per primam to a very high level, which was described and maintained by his pupils, Theodoric and Mondeville. When civilization declined after the 13th century, the believers in laudable pus wiped out this progress. Though Ambroise Paré made a contribution to arterial ligation, only in the hands of the civilian, Lister, did wound healing rise above that established by Hugo de Lucca six centuries earlier.

In former times the professional military medical officer usually was a competent, if not an original, master of surgery. While army and civilian doctors were competing for Civil War soldiers in Washington and Baltimore, Charles Folts, Fleet Surgeon to Farragut, was operating around the clock, for days at a time, on those wounded in the bloody struggle to control the Mississippi from the Passes to Vicksburg. Burdenko, called from his professorship to be Surgeon General of the Soviet Armies in 1941, continued to operate in military hospitals until 1945, and averaged four mornings a week in the operating room. By the time the Spanish War opened our Fleet and Army surgeons had become desk officers. Military medicine has gone full circle from physicians without military title to men with military titles who no longer practice medicine or surgery, and never were masters of their craft, like Paré or Hugo de Lucca.

Much has been said of wounds, although battle casualties were far less important than disability and death from disease until the Japanese campaign in Manchuria in 1904. Many heroic soldiers, like the poets Lord Byron and Rupert Brooke, died of diarrhea before they saw a battle, and scores of thousands died of pneumonia, cholera, plague, malaria, enteric and spotted fevers. Scurvy decimated fleets and determined the outcome of winter campaigns. Disease still took a frightful toll in the campaigns of 1914 - 1918, but so gigantic and destructive were the battles that wounds were even more deadly. On one arc, 20 miles across, more men were killed and wounded at Verdun than in

centuries of European warfare—twice as many as wounds and cold struck down at Stalingrad, the greatest battle of World War II. Far larger than Stalingrad also were the battles on the Somme and at “Wipers.”

So well organized was this “meat grinder” on the Western Front that American surgical teams in 1915 and 1916 could arrange visits of weeks or months and depend on a steady flow of whatever type of injury they wished to study. As a result, we entered the war in 1917 with half a dozen eminent surgeons, highly skilled in military problems and familiar with the Surgeons General of our allies. None of these men was in the Regular Army or within commuting distance of Washington, so their assistance and advice were spurned. Some, like Harvey Cushing, barely escaped court martial for trying to be helpful, and at Armistice Day were still Lieutenant-Colonels. However, the Regular Army group had been challenged by the problems of the Canal Zone, and in meeting that challenge had kept from deteriorating as badly as usually happens in peace time. Medical manpower was relatively efficiently used, and military medicine in 1917 approached the level of good civilian practice.

At the time of Pearl Harbor, our military medical plant had been running down for 22 years, and no Gorgas had arisen to meet problems as intricate as those of the Canal. In peace all elements of the armed forces decay, but infantry and artillery less than the technical branches, whose more energetic officers are drawn away to many civilian openings for their talents. The engineers always have peacetime jobs with flood control and probably deteriorate least, while capable ordnance, signal corps, and medical corps personnel are soon drawn away. In peace, army surgeons have almost no professional chores and rarely study military history, strategy, tactics or even current events. After a decade or two of life in army posts they find political intrigue more familiar than life in the field or in busy professional services, but

their promotion is rapid and proportional to the number of physicians drawn into the Army from civilian life. Thus is to be explained the tremendous waste of medical manpower throughout the last war. Three years of stoutly resisted civilian pressure and infiltration of officers from civilian life were needed to bring military medicine as close to the best civilian practice as it had been in 1917. Because civilian standards were very much higher, battle casualties relatively low, and no influenza pandemic occurred, the record of military surgery in recent campaigns compares well with earlier wars, but the waste of trained personnel was inconceivably greater.

In 1917 the Hospital Units at Harvard and at Washington University were in France within six or seven weeks after the war started and the Harvard Unit received its first convoy of 200 wounded 58 days after the declaration of war. Contrast the experience of the Cornell Unit which was only mobilized seven months after Pearl Harbor and then lay idle at Fort Andrews, on an island off Nantasket, for 367 days. It finally was sent to the Pacific, passing a Stanford Unit en route to the Mediterranean, but did not receive patients until nearly two years after war had been declared. Throughout the war thousands of physicians were idle in various pools, some of them for months at a time, and so abundant was talent that outstanding surgeons and internists spent the entire time in service as inspectors, there being no need for them to operate or conduct medical services. It was as though Special Services had so many fine musicians on tap that Horowitz, Menuhin and Lawrence Tibbett could be employed to arrange programs while others did the virtuoso acts.

So stable and efficiently organized was the Western Front in 1917 that an American college student with vision below our military standards could go to work in an ambulance unit at Verdun three weeks after leaving school and two months after the declaration of war. Thus he came to observe French army surgeons at casualty clearing stations, evacuation and railhead

hospitals. He also came to share the attitude of men in the battle zone toward those on the staff or in the metropolitan centers. The Elizabethan version of this military phenomenon found expression in Shakspeare's speech for Harry Hotspur, so magnificently declaimed by Lawrence Olivier:—

"But I remember when the fight was done,
When I was dry with rage and extreme toil,
Breathless and faint, leaning upon my sword,
Came there a certain lord, neat, trimly dress'd,
Fresh as a bridegroom and his chin new-reap'd
Show'd like a stubble field at harvest-home.
He was perfumed like a milliner
And as the soldiers bore dead bodies by
He called them untaught knaves, unmannerly,
To bring a slovenly unhandsome corse
Betwixt the wind and his nobility.
I, then all smarting with my wounds being cold,
To be so pester'd with a popinjay,
Out of my grief and my impatience
Answered neglectingly. For he made me mad
To see him shine so brisk and smell so sweet
And talk so like a waiting gentlewoman
Of guns and drums and wounds—God save the
mark!"¹

It soon became evident to our young spectator that the French surgeons and wounded alike had respect, even brotherly sympathy, for the Germans opposite them, a quiet contempt for and envy of all civilians, and an active dislike of men in uniform who never entered the zone of fire or bore the weight of ceaseless toil. In the French Army, with less than two doctors per 1,000 men, very few medical officers were free of a heavy load of professional work among the sick and wounded, and morale was generally high, even though professional standards seemed queer to our ambulance driver, whose bacillary dysentery was treated with powdered opium, and advice to drink blackberry brandy and buy newspapers printed on less abrasive sheets.

By the time the World Wars entered their 1940 phase our student had become a professor with some experience in medical problems of aviation, gained as consultant to flight surgeons for Pan American's Pacific venture, and more in the fields of

desert and mountain hygiene. But the naval air surgeon couldn't get this physician's central scotoma of one eye past the medical examiners and a doctor with better vision than Admiral Nelson had at Cape St. Vincent, the Nile or Trafalgar obviously was not good enough for our Navy. The Army didn't find the scotoma, when he responded to an invitation to do investigations in aviation problems, but the Air Force decided he would be more useful running a laboratory, though he had had no training in clinical pathology. When he was asked to join an armored division training for desert warfare, he thought he would be moving into a useful post, and he would have been if the clerks in Washington had not made out his orders incorrectly. As a result, our professor had five months' vacation in uniform in California as a minute cog in the Service of Supply, and four months at Fort Andrews, enlivened by escorting a trainload of Wacs from Bangor to Louisiana. Then he completed his only noteworthy military feat, getting sent back to his civilian job. His colleagues at Fort Andrews began actual care of patients nearly a year later, and at war's end had been idle more than two thirds of their time in service.

Later, as a civilian, our observer spent three weeks as consultant at the Army Institute of Pathology, an excellent example of intelligent planning by Regular Army officers, and three weeks as a visiting internist at Army Hospitals in Texas, just as the war ended. Obviously much progress had been made in four years and the Army was entering the next period of disarmament with a very capable group of Regular Army medical officers, thanks to the pressure of war. With only five years of atrophy, the Korean campaign finds us doing better medically than at the start of any previous war. Evacuation of wounded, use of physicians, and adaptability to new conditions set a new standard. Our Army was soon able to admit that the helicopter had been quite helpful to the Marines as an ambulance, and quickly put it in use for Army personnel. We now use air

¹ Henry IV, Part I, Act I, Scene 3.

evacuation as efficiently as the Germans did in 1936, when men wounded on the Ebro were in a Munich hospital 24 hours later.

To anyone who has made a superficial study of history, two parallels for the present era come constantly to mind. The effect of Marx's doctrine in the 19th and 20th centuries has been something like that of Mohammed's revelations in the 7th and 8th. Islam's westward sweep was halted 200 miles from Paris 100 years after the death of the prophet, but for nine centuries more the West was threatened, and the last assault was turned back at Vienna fifty years after the founding of Harvard College. The centennial of Marx's death is 1983, and we will be fortunate if the Western sweep of Marx, as turned to the purposes of Oriental despots, has then reached its farthest point. Judged by the history of Islam and the rate of spread of the two movements in their first century, Marxism probably will still be holding sway over Asiatic and Slavic lands twelve centuries from now.

Our forefathers learned to hold Islam at bay, and we must steel ourselves for a comparable struggle. The appeal of Communism for the Oriental or European peasant and for the competent physicists Fuchs and Curie-Joliot is as strong as the appeal of Islam ever was to ignorant camel driver or erudite Persian scholar. Such religious movements cannot be wiped out by campaigns, no matter how successful, nor can Russia or China be occupied by an invader.

Even if we go to war formally with China or Russia, we should not base our plans on our wars with Japan or Germany, and we might remember the outstanding lesson of our Civil War, confirmed in Germany twice in this generation — defeat and occupation do not make the defeated disown their leaders or their ideology, or accept that of the conquerors. Gene Talmadge stands firm with Jeff Davis, and the voters of Georgia are with him. In Paris one sees monuments to Napoleon on every side, and even a mediocrity could

govern in his name a generation after his crushing defeat. We should never seek to change the minds of those we defeat, should occupy their cities as briefly as necessary, or, best of all, crush aggression without attempting occupation. From the military standpoint the Crusades were costly failures in the struggle with Islam.

Our immediate problem is much like that with which the British had to deal during the Napoleonic Wars, which occurred when an able young tyrant seized control of a powerful revolutionary movement, and conquered all of Europe west of the Niemen river in Poland. England's expeditionary forces had very early been pushed into the sea at Toulon and Walcheren, and another was later pushed off at Corunna in Spain. But, in the Tagus Valley in Portugal, they defeated the Spanish stooges of the French, and for eight years held their precarious toe-hold against Napoleon's finest generals. Munitions came by sea from England at a fraction of the cost of overland freight from Paris, and Napoleon never could maintain a large enough army long enough. In the end Napoleon's empire crumbled and he ascribed this to the "Spanish ulcer" as much as to his Russian campaign.

Campaigns in Korea, Indo-China, the oil fields of the Middle East, or the peninsulas of Europe, face Russia and China with the same disadvantages Napoleon struggled with in the Peninsular War. England, without conscription, without loss of economic power or reducing the size of its college population, had defeated Napoleon by forcing him to antagonize all his neighbors, conscript all the young Frenchmen, and exhaust his resources. To Spain and Portugal, to Prussia and Russia, the cost of that victory was intense suffering and impoverishment. England's only crushing defeat occurred at New Orleans, six months before Wellington's victory at Waterloo. The United States, buying the territory Napoleon had seized from Spain, became the world's most successful receiver of stolen goods. Others probably will profit similarly during our struggle

with the empires which call themselves Marxist democracies.

If we are to judge by these long-range strategic considerations, the military medical program which, at extravagant cost, sufficed in the last war, is now completely obsolete. Civilian casualties, high in Spain and in the last war, have probably reached a new high in Korea, among our allies as well as our enemies. They may become very heavy in North America within a few years. To meet these new problems the military medical service should be welded with the civilian medical plant along the lines of the recently re-organized veterans' program. Necessary personnel for relatively stable installations in this country can best be secured by drafting men 50 to 70, whose educations are complete and children mature, rather than by taking men from residencies. The older men are overworked when young men are drafted, and the latter endure dull routine less tranquilly. The training of competent men can not be curtailed on the eve of a struggle of decades' duration without imperiling the whole defense plan. This is true of medical students and of others in science and the arts, but particularly of residents being trained in teaching hospitals. An army which cannot wait two or three years to get a trained surgeon or engineer instead of an untrained person is doomed in a crisis of long duration.

No one with less than three years post-graduate training should be used for the surgical teams or hospital staffs in combat zones, although they could be used in large military hospitals as interns or residents. If all full-time faculty and clinic members are available for three to four months' service in Army hospitals, each year, or one year out of four, the partition separating civilian and military medicine will begin to break down. The defects of the military system will be dealt with sooner, and its true needs will be authoritatively established. Teaching of young men in the service will be improved immensely by this arrangement.

Equally essential is the organization of

reserve units available as surgical teams for combat zones, or civilian disasters, and of hospital units to be called up as need develops. The whole system of battalion, regimental, division and corps surgeons, a relic of the days of horse-drawn armies and horse-back dispatch riders, should be revised. Better service can be rendered by dispensaries and hospitals for military units out of the combat zone, and by surgical teams and sanitary units to operate with field forces, the number depending on actual need, not merely on number of troops.

All units in reserve should practice for rapid mobilization, and with air transport could be made available swiftly wherever they were needed. The whole medical service should be freed from the Service of Supply, and be headed by men who have access to commanding officers at all levels up to the Defense Secretaries in Washington. Decentralization of geographic units, with unification of general hospitals for all services, is essential. It is wise to have medical services specifically designated to serve with Army, Navy, and Marine combat forces to improve morale and to provide competition in evolving better techniques. The Veterans Hospitals should be used for chronic care, and for those with permanent disability coming as soon as possible from the services.

The regular medical corps should have a system of compulsory retirement with age analogous to but more rigorous than that of British Navy officers. Majors should be retired by 35, colonels by 40 and generals by 50 in order to keep these men at the same levels of ability and responsibility as their civilian contemporaries. It should be the expectation that every military medical officer would become a civilian doctor in a few years, and would be competent enough to earn his living in a clinic, a medical school, private practice, industrial medicine, or public health. Promotion should be based on merit, not on senescence and political ability or opportunity. The professional competence of general officers should be approved by

a distinguished lay committee. All officers without responsibility for care of patients, even though M.D.s, should be listed as medical administrative, not medical corps. Only in this way can the services have superior officers able to command the respect of their subordinates and of fellow officers in combat units, and of the leaders of the profession. As long as the higher officers have no routine professional duties, they appear in the eyes of officers in combat areas or active hospital services as modern counterparts of the staff officer who roused the ire of Percy Hotspur. To the men who do the work, all desk surgeons are the modern equivalents of Shakspeare's "popinjays," "milliners" and "waiting gentlewomen." This statement is not intended to belittle decent patriotic men who have been demoralized by our neglect during all the years of peace, they are meant only to describe a state of affairs which must be remedied. None of the blame should fall on the incompetent officers revealed to us in 1941 or on the competent ones now in command of the services. Sweeping reforms are long overdue. They must come from civilians, for in our country, as in Russia, the Army takes its orders from civilians. We hope that this reform and the many others needed to gird us for the years ahead will come soon.

One shocking contrast to the student of history who considers our situation is the advanced age of our leaders, political, military and medical, compared with those who led us through the Revolution and the victorious years of the Civil War, or

with the British leaders in the struggle with Napoleon. Jefferson wrote the Declaration of Independence at 33; Wellington was 38 when he took command in Portugal; the Prime Minister, William Pitt, was 34 when France declared war on his country. Grant was 42 when he took over supreme command and the Army of the Potomac. Napoleon was 28 when he completed his Italian campaign and forced Austria to accept peace on his terms. Metternich, becoming Foreign Minister of Austria at 36, in five years restored her to the dominant continental place from which Bonaparte had humbled her. While men of outstanding ability, like Clemenceau or Churchill, who spend most of their lives in the opposition, may be good even at 65 or later, good young men will always beat good old men, in every field of human endeavor, from the prize ring to statesmanship, from music to organizing great industries. We need good young men, in positions of supreme responsibility, in as many fields as possible. In medicine we have never hesitated to give great responsibility to young men, and have rarely been disappointed. William Welch became dean at Hopkins when he was 34; Evarts Graham became chief of surgery at Washington University at 35; Osler, chief of medicine at Pennsylvania at 36. Similar selections for the military medical services are urgently needed. Asclepius in Arms must become as young, strong, adaptable and imaginative as Asclepius in the shrine of healing or the temple of science. Indeed, he should be one and the same.

Harvard Medical Society Meetings

JANUARY MEETING

The January meeting of the Harvard Medical Society was held on January 9 at the Bigelow Amphitheater, Massachusetts General Hospital. The program was presented by the Hospital's Departments of Neurology, Neurosurgery and Psychiatry, Dr. Stanley Cobb presiding.

Papers included the following: "Brain Abscess: Summary of Clinical and Pathological Findings," Dr. Edward P. Richardson, Jr.; "Radioactive Potassium: A New Isotope for Brain Tumor Localization," Drs. Bertram Selverstone and William H. Sweet; "Preliminary Observations on Mental Disturbances Occurring in Patients under Therapy with ACTH and Cortisone," Drs. Lincoln D. Clark and Stanley Cobb.

Dr. Richardson's paper dealt with a clinico-pathological survey of 42 fatal cases of brain abscess covering a fifteen-year period. Virtually all of the cases studied came to medical attention before the advent of effective chemotherapy.

The source of infection in the brain in this particular series of cases was pyogenic infection of the middle ear, mastoid and frontal and ethmoid sinuses. Although the patients had active infection of the ear or sinuses—acute or chronic—it was not possible, on the basis of available clinical evidence, to tell when the brain abscess began, except it could be seen that there came a time when the patient was distinctly more ill than before. The most frequent single symptom was headache, usually on the side of the abscess. The most important feature of the headache was that even though it might be intermittent and fluctuating, it became progressively worse.

The duration of the illness attributable to brain abscess ranged from a few days to six years, but usually the patients died in two to eight weeks following the onset of severe headaches.

Death was generally from respiratory failure. In a few cases the sudden appearance of a purulent spinal fluid together with rapid deterioration of the patient's condition indicated rupture of the abscess into the ventricular system.

Study of pathological material showed that in the vast majority of cases, infection apparently had reached the brain by direct extension from the primary focus, even in cases where there was an associated thrombophlebitis. Only in five cases could it be said with certainty that the pathway of infection was via a thrombosed vein; in these cases the abscesses tended to be multiple and to be located at some distance from the primary focus. In many cases, Dr. Richardson emphasized, pathological studies failed to divulge with absolute certainty the pathway of infection, making it exceedingly difficult to elucidate the exact pathogenesis of this condition.

Dr. Selverstone reported that radioactive potassium, K^{42} , injected intravenously, reaches within a few hours concentrations much higher in many cerebral tumors than in normal brain, and that K^{42} offers promise as a substance which may be useful for the localization of many cerebral tumors through the intact skull.

The investigators said that K^{42} localizes in high concentration in most cerebral tumors as compared with normal brain, although astrocytoma may constitute a major exception.

Activity ratios in most tumors are comparable to those obtained with P^{32} , but the time interval for optimum concentration of K^{42} is shorter than the 12 to 48-hour period characteristic of P^{32} . With K^{42} , maximum ratios are obtained from within a few minutes to five or six hours after injection of the isotope.

The method of counting with a 2 mm. Geiger-Mueller probing counter is satis-

factory for localization and demarcation of cerebral tumors at operation employing K^{42} , but is inherently a less accurate technique than that employing P^{32} . It has the advantage that, in an emergency, satisfactory results may be obtained within a few minutes after injection of the isotope. The short half-life of K^{42} , 12.44 hours, makes it inconvenient for routine use.

External localization of many cerebral tumors by means of K^{42} is a practical technique, but the authors assert they cannot at the present time recommend it for routine use. It was said that with the development of rectangular scanning techniques at a distance from the head, it may well become a clinical tool.

The paper by Drs. Clark and Cobb was read by Dr. Clark. It represented a preliminary clinical presentation of ten cases of mental disturbance, which occurred at the Massachusetts General Hospital during the past year, in patients under prolonged therapy with relatively large doses of ACTH or cortisone for medical illness (including rheumatoid arthritis (7), Reiter's syndrome (2), and chronic disseminated lupus erythematosus (1).) In none of these cases was there an antecedent history of frank psychiatric illness.

The cases were arbitrarily divided for descriptive purposes into minor (4) and major (6) disturbances. The former, including mild degrees of anxiety, depression, behavioral change and depersonalization, appeared to represent in transient, discrete form some of the features present in the more complex major disturbances. Coincident with the mental symptoms, all of these cases, as well as several of the patients with major disturbances, suffered quite characteristic paresthesias of the frontal portion of the head. These sensations were described as feelings of "pressure", "tightening", or "congestion" of the forehead.

The major cases included mental disturbances of psychotic proportions, lasting as long as three months. Although the course of their psychoses in longi-

tudinal view was not that usually seen in the schizo-affective psychosis or toxic deliria, they exhibited in an unstructured, kaleidoscopic manner almost the entire gamut of psychotic symptomatology seen in the latter disorders. Gradual recovery occurred in all cases.

In this group of patients no significant correlation was observed between the occurrence of mental symptoms and urinary excretion of 17 keto-steroids, serum levels of sodium, potassium, or other electrolytes, or intracellular potassium as evidenced by electrocardiographic changes. However, it was pointed out that further metabolic studies must be carried out before any definitive conclusions can be drawn in this regard.

Recent experimental work correlating disturbed adrenal function with major psychiatric illness and the frequent coincidence of psychosis and Cushing's disease were briefly described as an introduction to the hypothesis that exogenous ACTH and cortisone in certain cases may, by an unknown metabolic mechanism, cause a disorder of psychotic proportions in the intellectual, affective, and apperceptive functions of the brain. It was suggested that further study must be carried out to determine possible psychogenic or metabolic factors involved in individual susceptibility to these disorders.

FEBRUARY MEETING

The February meeting of the Harvard Medical Society was held on February 13 at the Peter Bent Brigham Hospital Amphitheater. The program was presented by the Departments of Pathology and Pediatrics, Children's Medical Center, Dr. Charles A. Janeway, presiding.

Papers included the following: "Lipoprotein in Gaucher's Disease", Dr. L. Lahut Uzman; "Sodium Deficity Produced by Uretero-Arachnoid Anastomosis." Drs. William M. Wallace, Donald D. Matson, Robert Schwartz and William H. Bergstrom; "Control Effects of Antigen-Antibody Reactions on the Tissues," Drs.

Ralph J. P. Wedgwood and Charles A. Janeway.

Dr. Uzman discussed the isolation, from two spleens removed surgically from persons with Gaucher's disease, of a lipoprotein fraction containing 62 per cent kersasin.

From a variety of evidence, many investigators have concluded that the kersasin in the Gaucher cell may be present in a "bound" form, bound probably to some normal constituent of the cell. Since the cellular protein is the constituent most likely to be affected by the procedure commonly employed in the isolation of the cerebroside, Dr. Uzman envisioned the kersasin in the Gaucher cell to be present as a kersasin-protein complex, which would split to yield the free cerebroside only after denaturation, or drastic alteration in the spatial relationships of the protein moiety, had taken place.

Because the lipoprotein fraction which he isolated accounts for the major part of the so-called abnormal lipid that chemically characterizes Gaucher cells, and because of its rather special properties, Dr. Uzman felt justified in designating the fraction the lipoprotein of Gaucher's disease (GLP).

The cerebroside content of the fraction was found to account for more than 70 per cent of the kersasin present in each of the two spleens. Studies on the isolated lipoprotein fractions have shown a remarkable tenacity for the lipid-protein bond which is broken only on prolonged boiling with chloroform-methanol, or by treatment with a protein denaturant such as 8-M guanidine-hydrochloride.

The native lipoprotein was found to be resistant to the action of proteolytic enzymes, although the organic anion binding capacity of the fraction has indicated that a large part of the peptide coils are available at the surface of the lipoprotein macromolecule.

It was concluded that the cerebroside which chemically characterizes the Gaucher cell is firmly bound within the cell in the form of a lipoprotein, the

rather distinctive properties of which will have to be considered in any future formulation of concepts regarding the pathogenesis of Gaucher's disease.

Dr. Wallace's report concerned investigations which have followed the development, by Dr. Matson, of a surgical procedure for the relief of hydrocephalus. This operation consists of removing one kidney and anastomosing its ureter to the lumbar subarachnoid space.

In properly selected children, the operation produced good long-term results with relief of the hydrocephalus and continuing favorable developmental progress. The major complication to arise from the procedure is the dehydration that results from the unrestrained loss of spinal fluid. Intake of sodium and chloride must be maintained at a high level without fail if severe dehydration is not to follow. Compensation to the loss by the remaining kidney is good but, when intake falls, it is always insufficient.

The effect of a low sodium intake on operated children was studied to determine the magnitude of the loss as well as to investigate the distribution of the body water losses. When such children are placed on diets with a normal water, chloride and potassium intake but deficient in sodium, dehydration occurs quickly with the loss of about ten per cent of body weight in 48 hours. The weight loss is about equally distributed between the extracellular and intracellular phase. In this type of dehydration, where pure deficit of sodium is produced, it was shown that chloride seems to be the principle factor determining the distribution of water loss. Continued loss of sodium with adequate replacement of potassium, chloride and water was shown to lead to extensive loss of intracellular sodium with reciprocal increases in the amount of potassium in the intracellular compartment. Potassium replacement is inadequate to restore osmotic equality and probably accounts for the loss of intracellular water.

When renal equilibrium on a diet con-

taining no sodium is reached, it was shown that the sodium in the urine may be used as a measure of spinal fluid loss. Attainment of this equilibrium is approximately complete in about 24 hours. Analysis of the data indicates that from 100 to 200 ml. of spinal fluid per day are lost. This prescribes a replacement of salt to the extent of two to three grams a day.

Drs. Wedgwood and Janeway presented evidence suggesting that the suppressive action of nitrogen mustards and X-radiation on hypersensitive lesions appears to be by inhibition of the production of antibodies, while ACTH prevents the development of lesions in spite of the production of antibodies. This would indicate that ACTH protects the tissue itself from the noxious effects of antibody-antigen interaction.

The authors pointed out that many workers have shown that glomerular and vascular lesions can be produced regularly in experimental animals by the injection of foreign proteins, and the pathologic similarity between these lesions and those found in various diseases (the so-called collagen and hypersensitivity diseases) in humans is well documented.

Studies have shown a definite pattern in the serologic sequences leading to the production of the pathologic lesions. The initial event is the injection of the antigen, following which time antigen may be demonstrated circulating in the serum. Over a period of time, an incubation period, the concentration of circulating antigen decreases and the serum complement titre falls. By the time the circulating antigen disappears from the blood stream the depression of the serum complement is maximal and circulating antibodies begin to appear. It is at this time that the pathologic lesions appear at their height.

These serologic sequences found experimentally show some similarities to their pathologic counterparts in humans. Such immunologic similarities do not prove that an immunologic mechanism is the sole factor in the human diseases, and do

not take into account the constitutional, metabolic and environmental factors which also seem to play a role in these diseases in humans. But the inference that the immunologic mechanisms are important in their pathogenesis is accepted by many workers.

The experimenters asserted that the study of these mechanisms is made most advantageously by the injection of a single, purified antigen, which can be identified easily, in an experimental animal which may be sacrificed at any time for observation of the pathologic changes. The antigen, in these experiments, was purified bovine serum gamma globulin. The animal was the rabbit.

Experiments at Children's Medical Center and observations of other workers suggest the following hypothesis:

1. Part of the introduced antigen, circulating in the serum, becomes fixed in the kidney tissue.
2. Part of the same antigen stimulates the various sites of antibody formation to produce antibodies.
3. This antibody reacts with the tissue fixed antigen and in some manner, perhaps as a result of its union with complement, produces tissue damage. The action of complement may well be similar to its action in other lytic phenomena.
4. Tissue damage is manifest by lesions that can be visualized and are called glomerulonephritis.

If the hypothesis is correct, lesions resulting from such delayed hypersensitivity responses might be prevented by breaking the chain reaction at one of its links: by preventing the production of antibodies, by inhibiting the interaction of antibody and antigen, perhaps by the inactivation of serum complement, or by protecting the tissue against the noxious effect of these interactions.

The production of antibodies in the rabbit can be prevented by massive X-radiation, and such X-radiation will also prevent the development of renal lesions following the injection of bovine gamma

globulin. The administration of nitrogen mustards will produce the same effect.

Interest in the adrenal steroids led the investigators to evaluate the action of ACTH on rabbits subjected to experimental procedures similar to those used in the X-ray and nitrogen mustard experiments. Evidence suggests that ACTH has a different action than X-radiation or nitrogen mustards. The action of the X-rays and mustards demonstrates the dependence of the serological sequences and the appearance of renal lesions on the development of antibodies. If the production of antibodies is prevented, these serologic changes do not occur, and lesions do not appear. But ACTH prevents the development of lesions in spite of the occurrence of these serologic sequences, in spite of the appearance of antibodies, and the evidence for the interaction of antibody and antigen as manifested by the rate of disappearance of antigen and the fall in the serum complement. This suggests that ACTH in some manner protects the tissue itself from the usually noxious combination of antigen, antibody and complement.

Record of a patient with disseminated lupus erythematosus, treated with ACTH and nitrogen mustards, was presented to suggest possible clinical applications of the experimental data.

CUTTER LECTURE

Delivering the 66th Cutter Lecture on Preventive Medicine at the Harvard Medical School on February 9, Dr. Hugh M. Sinclair, Director of the Laboratory of Human Nutrition at the University of Oxford, expressed the hope of closer collaboration in the future between the pure and applied science of human nutrition.

Speaking of a survey in liberated parts of Europe toward the end of World War II, Dr. Sinclair reported:

"We were faced in The Netherlands and Germany with the conduct of surveys for the specific and urgent public health purpose of establishing the incidence, cause and severity of malnutrition, and then of recommending treatment. There were, therefore, no opportunities for the detailed experimental study of a few cases, which is the method of choice for advancing fundamental knowledge.

"Had we gone with a government team whose function was the conduct of epidemiological surveys, their normal routine work would have been enlivened by the new experience; and our research would have been possible. But no such team existed. Fortunately controlled observations were made by others on a few malnourished persons during and after the war.

"In the future we may hope that all countries will have such epidemiological teams and such institutes for experimental research, and that there may be constant interchange of information between them and the joint field studies, especially within their own country but also with the corresponding teams and institutes in other countries.

"There are, unfortunately, large areas of the world where gross malnutrition exists, and surely combined studies by experimental scientists and nutritional epidemiologists should be made. We need close collaboration between the pure and applied science of human nutrition."

Dr. Sinclair is a Fellow of Magdalen College and was formerly director of the Oxford Nutrition Survey. The Cutter Lecture is given under the auspices of the Harvard School of Public Health.

Internships Class of 1951

Unless otherwise noted all *internships* start July 1, 1951 for one year.

Arnstein, R. L.	Syracuse University Medical Center	Mixed
Arthur, R. J.	Massachusetts General	Pediatrics
Atik, M.	Strong Memorial	Surgical
Baker, L. M., 3d	Geisinger Memorial, Danville, Pa.	Rotating
Bell, Ellen	Massachusetts General	Pediatrics
Bell, G. A.	Wadsworth V. A., Los Angeles	Medical
Bellis, J. M., Jr.	St. Elizabeth's, Washington, D. C.	Rotating
Bikoff, D. M.	Beth Israel, Boston	Surgical
Boomer, R. B.	Los Angeles County	Rotating
Bossi, E. E.	Rhode Island Hospital	*Rotating
Bradshaw, J. S.	University Hospitals, Cleveland	Surgical
Bryan, J. E.	Boston City	Medical
Bullard, H. V., Jr.	Vanderbilt University Hospital	Medical
Burke, J. F.	Massachusetts General	Surgical
Burke, S. K.	Duval Medical Center, Jacksonville, Fla.	Rotating
Cain, A. J.	Mary Hitchcock Memorial, Hanover	Rotating
Campbell, J. E.	Kings County Hospital System, Brooklyn	Medical
Chaney, R. H.	Los Angeles County	Rotating
Chapman, R. G.	Hartford Hospital	*Rotating
Clapp, P.	New York Hospital	Surgical
Clark, T. R.	Mary Hitchcock Memorial, Hanover	Rotating
Damon, A.	Massachusetts General	Medical
Danforth, W. H.	Barnes, St. Louis	Medical
Davis, R. P.	Peter Bent Brigham	Medical
Dawson, Jean P.	Bellevue	Pediatrics
DeForest, R. E.	Mary Hitchcock Memorial, Hanover	Rotating
DiRaimondo, V. C.	Peter Bent Brigham	Medical
Dreyfus, E. G.	Boston City	Medical
Early, R. L.	Henry Ford	Rotating
Efron, Mary L.	Peter Bent Brigham	Medical
Ellison, A. E., 3d	Peter Bent Brigham	Surgical
Elser, O. H.	University of Kansas Medical Center	Rotating
Fahey, J. L.	Presbyterian, N. Y.	Medical
Fernald, W. B.	Boston City	Medical
Field, J. B.	Massachusetts General	Medical
Fischbein, J. W.	Beth Israel, Boston	Medical
Fordham, C. C., 3d	Georgetown University Hospital	Medical
Foster, G. S.	Massachusetts General	Medical
Fraser, G. C.	Presbyterian, N. Y.	Surgical
Fromm, S. R.	Duke University Hospital	Medical
Frothingham, T. E.	Bellevue	Pediatrics
Galdston, R.	Boston City	Surgical
Garrett, J. J., Jr.	Albany Hospital, N. Y.	*Rotating
Gauchat, R. D.	University of Minnesota Hospital	Pediatrics
Geschwind, N.	Beth Israel, Boston	Medical
Ginandes, S. C.	Massachusetts General	Pediatrics
Goodrich, C. H., 2d	King County Hospital System, Seattle	Rotating
Gordon, M. L.	Presbyterian, N. Y.	Surgical
Gould, J. C.	Presbyterian, Chicago	Rotating
Gravallese, M. A., Jr.	Boston City	Medical
Greenbaum, J. K.	Mercy Hospital, Pittsburgh	Rotating
Guattery, J. M.	Bellevue (III Div.)	Medical
Hayes, D.	Walter Reed General	Rotating
Haymond, T. A.	Philadelphia General	Rotating
Haynes, W. M., Jr.	Massachusetts General	Surgical

Hess, Helen H.	USPHS Fellowship in Biochemistry	
Heusinkveld, D. W., Jr.	McLean Hospital, Waverley	
Hiebert, C. A.	Salt Lake City General	Rotating
Holloman, J. J.	Massachusetts General	Surgical
Hoye, S. J.	U. S. Naval Hospital, Oceanside, Calif.	Rotating
Hudson, B. H.	Peter Bent Brigham	Surgical
Hutchison, G. B.	Strong Memorial	*Rotating
Jefferson, Mildred F.	Massachusetts Memorial	Medical
Jencks, W. P.	Boston City	Surgical
Jones, R. L.	Peter Bent Brigham	Medical
Jones, W. F., Jr.	U. S. Naval Hospital, Oceanside, Calif.	Rotating
Karlen, W. S.	Boston City	Medical
Kellum, J. B.	Beth Israel, Boston	Medical
Kiely, B.	Roosevelt, N. Y.	Surgical
Kirn, G. J.	Massachusetts General	Medical
Kleaveland, R. N.	University Hospitals, Cleveland	Pediatrics
Kliwer, D. D.	Massachusetts General	Surgical
Krakauer, L. J.	New York Hospital	Medical
Kushnick, T.	Bellevue (II Div.)	Medical
Labbe, J. P.	Boston City	Medical
Lacy, W. W.	New York Hospital	Surgical
Lamdin, E.	Johns Hopkins Hospital	Medical
Lohnes, W. E.	Boston City	Medical
Ludwick, J. P.	City Hospital, Cleveland	Rotating
Lyon, W. H., Jr.	Cook County Hospital, Chicago	Rotating
Manson, W. G.	Roosevelt, N. Y.	Mixed
Marsh, S. H.	San Francisco Hospital, U. of Calif. Service	Rotating
Matthews, H. B.	University of Chicago Clinics	Rotating
May, H. L.	St. Elizabeth's, Washington, D. C.	Rotating
Mayo, R. A.	University of Minnesota Hospitals	Medical
McDuffie, F. C.	Mary Imogene Bassett, Cooperstown, N. Y.	Surgical
Meadows, P. M.	Peter Bent Brigham	Medical
Moore, R. F.	USPHS, Brighton Marine Hospital	Rotating
Murphey, B. G.	Peter Bent Brigham	Surgical
Murphy, G. B., Jr.	Presbyterian, Chicago	Rotating
Neely, W. A.	Massachusetts General	Surgical
Nevis, A. H.	Barnes, St. Louis	Surgical
Nielsen, R. L.	Stanford University Hospital	Surgical
Norris, F. G.	King County Hospital System, Seattle	Rotating
Novick, A.	Peter Bent Brigham	Surgical
Oates, R. G.	Beth Israel, Boston	Medical
Olson, R. E.	Boston City	Surgical
Palladino, N. M.	Peter Bent Brigham	Medical
Peebles, T. C.	Philadelphia General	Rotating
Perrin, G. M.	Massachusetts General	Pediatrics
Plum, G. E.	Boston City	Medical
Quackenbush, A. C.	New York Hospital	Surgical
Reid, R. C.	St. Albans Naval Hospital, N. Y.	Rotating
Reusch, D. C.	Boston City	Medical
Richardson, D. W.	University Hospitals, Cleveland	Medical
Richter, T.	Grace-New Haven	Medical
Robey, J. S.	Presbyterian, N. Y.	Medical
Roth, D.	Boston City	Medical
Rowe, J. C.	Research and Educational Hospitals, Chicago	Rotating
Rubinstein, N. E.	Massachusetts General	Medical
Schonfeld, M. D.	Kings County Hospital System, Brooklyn	Medical
Sears, Jane B.	Beth Israel, Boston	Medical
Shaffer, F. G.	Roosevelt, N. Y.	Medical
	Massachusetts General	Surgical

Simpson, W. F.	Peter Bent Brigham	Surgical
Singh, M. M.	Massachusetts General	Medical
Skinner, A. L., Jr.	King County Hospital System, Seattle	Rotating
Sluis, J.	University of Chicago Clinics	Rotating
Snow, D. B.	Boston City	Medical
Stallard, S. K.	Henry Ford	Rotating
Stanford, J.	Hartford Hospital	*Rotating
Stetson, J. B.	V. A. Hospital, Salt Lake City	Medical
Strober, M.	Kings County Hospital System, Brooklyn	Mixed
Sult, Elizabeth H.	Providence Hospital, Portland, Ore.	Rotating
Sult, F. L.	Providence Hospital, Portland, Ore.	Rotating
Summer, G. K.	Vanderbilt University Hospital	Medical
Tetrick, J. E.	Massachusetts General	Surgical
Tisdale, W. A.	Massachusetts General	Medical
Toll, G. D.	Massachusetts General	Surgical
Tomchik, F. S.	Grace-New Haven	*Medical
Totherow, W. R.	Tripler General, USAF, Hawaii	Rotating
Tully, B. M.	George Washington Hospital, Washington, D. C.	Surgical
Tuttle, E. P., Jr.	Massachusetts General	Medical
Udall, A. R.	Los Angeles County	Rotating
Vickery, C. C.	Los Angeles County	Rotating
Watson, P. L.	Massachusetts Memorial	Medical
Weiner, A. D.	Long Island College Hospital	Medical
Weiss, Ruth S.	Massachusetts General	Pediatrics
Wheeler, H. O., Jr.	Presbyterian, N. Y.	Medical
Wilmer, E. P.	Hartford Hospital	Rotating
Wingate, J. H.	King County Hospital System, Seattle	Rotating
Wiygul, F. M., Jr.	Charity Hospital of Louisiana	Rotating
Woodbury, M. A.	Los Angeles County	Rotating
Woodward, G. H.	New England Center Hospital	Medical
Yaffee, H. S.	Newington V. A. Hospital, Conn.	Medical
Yanagi, G. N.	Biochemical and chemical studies at University of Wisconsin	
Zoglin, S. F.	Bellevue (II Div.)	Medical
Zukoski, C. F., 3d	Roosevelt, N. Y.	Surgical

*Two year appointment

Zabdiel Boylston (1679-1766)

Remarks at His Grave, May 22, 1950

HENRY R. VIETS, '16*

We, members of the American Association of the History of Medicine, pause here in the old Brookline cemetery at the place where Zabdiel Boylston was buried in 1766. He, the first in the British colony of Massachusetts Bay to use direct inoculation of smallpox matter as a means of preventing a more serious form of the disease, on June 26, 1721, was the leading physician of Brookline, then a small community known as Muddy River. The village, adjacent to Boston, was named after the little stream that runs near by, a brook that ultimately passes the Boston Medical Library, where we have just met, on its way to the Charles.

Smallpox struck a savage blow to Boston and its vicinity in the spring of 1721. The few physicians were helpless in the face of an epidemic of a frequently fatal disease. Only the learned divine, Cotton Mather, seems to have known of the practice of preventing smallpox by direct inoculation. This knowledge came to him from a slave, Onesimus, presented to him by his parishioners in 1706, who had been inoculated in Africa as a member of the Garamantes tribe and thus was immune to smallpox. This direct evidence was reinforced by Mather's reading of the *Transactions of the Royal Society*, a publication he received as a member. In an issue he found an account of inoculation as practiced in Turkey and later strongly advocated by Lady Mary Wortley Montagu, wife of the British ambassador in Constantinople. Mather's keen scientific mind was aroused and, convinced of the value of inoculation, he urged its use in Boston, in a public "Address", dated June 6, 1721. His communication was ignored by public and physicians alike. Again Mather spoke, this time in a "Letter", written on June 24, to the forty-two year old Boylston, a home-spun doctor, self educated and without a medical degree.

Boylston's hour had come. Two days later, he inoculated his son, Thomas, and his two Negro slaves. Success followed quickly; soon the country doctor, in spite

of much opposition, extended his observations and his list of favorable cases grew into scores. He published his report within a couple of years; an orderly, concise and convincing account. Called to London, Boylston was honored by being made a Fellow of the Royal Society, under the presidency of Sir Isaac Newton, on July 7, 1726.

Inoculation by the direct method, its value fully demonstrated in Boston by Boylston, soon spread throughout the world. Immunity was thus established, preventing smallpox in its most terrifying form. This procedure lasted until inoculation was supplanted by Jennerian cowpox vaccination in 1798.

We stand here, almost opposite Harvey Cushing's old house, now demolished, and read with reverence, the faded inscription on the flat tombstone:

Sacred to the memory of Zabdiel Boylston Esq
Physician and F.R.S. who first introduced
the practice of Inoculation into America
Thro' a Life of extensive Beneficence He was
always faithfull to his word, just in his

Dealings

affable in his manners and after a long
Sickness in which he was exemplary for his
Patience

and Resignation to his maker he quitted this
mortal Life in a just expectation of a happy
Immortality, on the First day of March
A. D. 1766. Aetat 87

With him lies here buried Jerusha his wife
Who died the Fifteenth day of April
A.D. 1764. Aetat 85.

How could one wish for more in life than is implied by the simple words we read today, one hundred and eighty-four years after Boylston's death. He was "always faithful to his word, just in his dealings, affable in his manners and . . . exemplary for his patience." Sound principles for young doctors; good guides for historians. But Boylston was more than "a good doctor", for he, as did his later neighbor, Harvey Cushing, had the instinct of genius, grasping the "unknown" and making it known, serviceable, and beneficial to his fellow men.

*Reprinted from: Bulletin of the History of Medicine, vol. 24, Nov.-Dec. 1950, pp. 539-40.

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WAR AND THE DOCTOR

It is characteristic of a free society that professionals in many fields frequently receive unsolicited public advice from interested citizens. The slightest change in the fortunes of a baseball or football team brings forth the clamorous response of aroused fans. Every New Englander is convinced that he can prognosticate the weather better than the trained meteorologist whose salary he is paying. While most of such criticism is trivial the wise expert will realize that some is sound and useful.

That this freedom of comment is good is a basic tenet of our democracy. Without it, when general interest is absent, our most cherished and valuable institutions can easily sink into the torpor of complacency and self sufficiency. Elsewhere in this issue the sad state of the Medical Corps of the U. S. Army between World Wars I and II is described. The brilliant medical record of the second war was more the result of the efforts of tens of thousands of amateurs in uniform than of the planning of duly constituted professionals. Persuasion and education triumphed over entrenched authority and even stupidity, and no army in any recorded war was ever better served by doctors.

The return of the average amateur to civilian life was marked by a sense of relief and a strong disinclination ever again to have anything to do with a uniform, often expressed in unprintable terms. Now the stage is set for history to repeat itself. Once again armies are being assembled

and international insults are commonplace.

It behooves all followers of Aesculapius, however distasteful it may be, to keep a watchful eye on the professionals and they in turn should heed the thoughtful criticism of their one-time colleagues and teachers. There may not be enough time again.

CHANGE IN THE CONSTITUTION

Proposed Change in the Constitution

Article IV of the Constitution reads as follows: "The officers of the Association shall be a President, a Vice-President, a Secretary, a Treasurer, and nine councillors. The President, Vice-President, Secretary and Treasurer shall be *ex-officio* members of the Council."

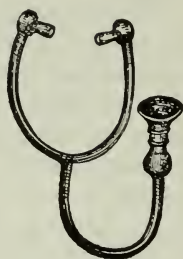
Article V, Section 1 of the Constitution reads as follows: "The President shall be elected annually. The Vice-President, Secretary and Treasurer shall be elected for the term of three years."

At the meeting of the Executive Council on February 3, 1951, it was felt that the term of one year for the President was too short a period to give effective leadership to the Council. Accordingly it was unanimously agreed that the President should serve a one-year term as President-elect previous to his year as President, and then *ex-officio* for one additional year on the Council. The Council therefore voted unanimously to recommend to the Alumni Association, at its next annual meeting to be held at Atlantic City, June 13, 1951, that Article IV and Article V, Section 1 of the Constitution be changed to read:

"*Article IV*—The officers of the Association shall be a President, a President-elect, a Vice-President, a Secretary, a Treasurer and nine councillors. The President, President-elect, Vice-President, Secretary and Treasurer shall be *ex-officio* members of the Council. The President shall also serve *ex-officio* on the Council for one year following his term as President.

"*Article V, Section 1*—The President and President-elect shall be elected annually. The Vice-President, Secretary and Treasurer shall be elected for the term of three years."

The Stethoscope



February, ordinarily a disagreeable month, is always pleasant at the Medical School for one particular reason. Dr. Christian's birthday falls on the seventeenth and on or about that day the Henry A. Christian Prize is awarded. Under the terms of the deed of its gift it goes "to the student in the Fourth Year Class who, in the opinion of the Committee of Award, has displayed diligence and notable scholarship in his studies and offers promise for the future. The Committee of Award should be made up of the Dean of the Medical School and a small advisory group selected by him." This year the Award was made on the day before Dr. Christian's birthday, in the Faculty Room, before a group of students and teachers. There was a birthday cake which Dr. Christian cut with appropriate ceremony, and a large tea. Then Dr. Samuel A. Levine, '14, introduced Dr. Christian who spoke about his early days in the School, commenting on the fact that certain aspects of medicine which he taught had been forgotten and were now being rediscovered. Finally, he gave the prize—in the form of a cheque—and a book from his own library to Elbert Parr Tuttle, Jr., this year's recipient. Tuttle is 29 years old, coming from Atlanta, Georgia, where his father is a lawyer. He graduated from Princeton in 1942, a straight A scholar; after serving in the Marine Corps Aviation Service for three years he came to the Medical School as a National Scholar. Here he has proved diligent and has displayed notable scholarship in his studies. He has always ranked high in his class, is a member of A.O.A. and from any point of view offers promise for the future; he is the fifteenth

Christian Prize recipient and, like his predecessors, seems likely to continue to make an outstanding record.—Earlier in the month Dr. Levine and Dr. Howard B. Sprague, '22, took part in an interesting experiment in postgraduate medical education. They joined in a three-way telephone discussion on heart disease arranged by the Indiana University Medical Center, the "telephone seminar" being carried from Indianapolis to doctors gathered in front of loudspeakers in 28 local Indiana Medical Societies. Doctors Sprague and Levine were joined by Doctors Arlie R. Barnes and Edgar Allen of the Mayo Clinic with Dr. George S. Bond, professor of cardiology at Indiana, acting as moderator. The round-table discussion that resulted was lively, unusual, and of distinct educational value.—February 20 was the day intern appointments were announced under the Uniform Intern Placement Plan. It was a busy day around the Dean's Office. Telegrams came in and went out, men receiving appointments they hoped for became jubilant, while those failing to receive immediate offers became depressed, Boston hospital representatives grew impatient at the reluctance with which persons offered their appointments seemed willing to accept them, and, in the meantime, hospitals from all over the country were telephoning for help in the filling of unfilled posts. The day ended at last and on the whole our men did well, managing to come close to obtaining what they wanted. The M.G.H. appointed twenty-one, the B.C.H. fourteen, the P.B.B.H. eleven, and the Beth Israel six. The remaining 87 members of the class will scatter over the country side; nobody was left out.—A few years ago, Dr. Paul D. White, '11, visited Athens as a member of the Medical Mission of the Unitarian Service Committee. While there he met Professor Skevos Zervos, a distinguished medieval historian, who said that he hoped some day to send to the Harvard Medical School a portrait of Hippocrates in appreciation of all the efforts the United States had lately made in be-



HIPPOCRATES

Portrait presented by Professor Skevos Zervos of Athens. It is from a statue supposed to have been made in the Fourth Century B.C. It was painted by Mr. Stephen Almaliotis.

half of Greece. It took many months for him to accomplish what he had in mind but at last the portrait arrived. It is a large portrait—nearly eight feet tall—and copies a famous statue of Hippocrates believed to have been made in the Fourth Century B. C. Last May Professor Zervos was able to come to Boston to make formal presentation of his gift. He proved to be not only a profound scholar but also a delightful man. When he unveiled the portrait in the Faculty Room, he said he hoped it would be displayed in a prominent place in the School so that all future Harvard Medical students would see it and be reminded of

the enduring value of the Hippocratic Oath. Dr. Frederic T. Lewis, '01, suggested the place for the portrait was on the stairway in Building B-I, for here all students would come to know it well; it now hangs there and already looks as if it felt at home and at peace.—Plans for Alumni Day and for Class Day, May 25 and 26, are taking form. Be sure to come!

Correspondence

CHINA CONTROVERSY

The article "China Chronicle," by Goodrich C. Schauffer, '23, which appeared in the October issue of the BULLETIN has occasioned considerable comment, much of which was stimulated by the following letter reprinted with the permission of "The New York Times":

*To the Editor of the New York Times:*¹

I am not a pacifist nor a Communist, but I hope I am a realist. Before it is too late there should be a movement among all clear-thinking people to prevent any war with China.

We in the United States profess great affection for the Chinese people. A war against China would add immeasurable suffering to the suffering these people have had to endure: years of civil war followed by invasion from Japan. At last they have a stable Government, whether we like the type or not.

We would never win a war in China. But we could bomb their towns and cities and cause untold misery among the masses for whom we profess such deep feeling.

If by chance the United States did upset the present regime, what would they put in its place? Would those people who advocate an aggressive war against Red China put Chiang Kai-shek and his corrupt Nationalist Government back into power?

In the October number of the HARVARD MEDICAL ALUMNI BULLETIN there appears an article by Dr. Goodrich C. Schauffer. This young doctor spent two years in China, and his description of the bribery, corruption and greed of the Nationalist Government is enough to convince us once and for all that the Nationalist Government was not a Government for the common people.

Drugs and hospital supplies donated by the United States Government were sold at exorbitant prices for the rich. The poor masses of China have no medical treatment. Because of

¹Letter published in the correspondence columns of "The New York Times," January 11, 1951.

their inability to pay they are refused admission to Government and mission hospitals. Dr. Schauffler paints a most terrifying and damning picture of the situation and, I take it, a true picture.

It would be the greatest tragedy of the human race if the United States Government, urged on by certain publications and Senators, precipitated us into a war with these helpless people—a war we could not win. There is no disgrace in meeting the leaders of China, admitting China into the United Nations and coming to some agreement with them.

CHARLES S. CURTIS, C.B.E., M.D.²
Superintendent, Grenfell Mission,
St. Anthony, Newfoundland,
December 29, 1950.

Ed.

Prompted by the above letter to read Schauffler's article in the BULLETIN, Mr. Watson Washburn (Harvard College, '14), a New York attorney, sent the following letter to the Editor:
To the Editor:

A letter recently published in The New York Times referred to an article by Dr. Schauffler in your October number. Reading the article (your leading one) I was shocked to find the statement that "the present outlook, from the standpoint of public health and medical care, is tremendously better than it has ever been in China."

As you might ascertain by reading Arthur Goodfriend's article in the Reader's Digest for January 1951, the fact is that China is now suffering from a plague of deaths by torture of innocent victims which far exceeds in horror anything ever endured there under previous regimes, from the standpoint of public health or otherwise.

I realize that you published Dr. Schauffler's article before the Chinese Communists had openly entered the Korean war against us. However, as a Harvard graduate, I question the wisdom of publishing articles favoring any aspects of Communism, at least without giving the other side of the picture. I believe it is your duty now to publish a leading article depicting the dark side of Chinese Communism. No doubt you could obtain permission from the Reader's Digest to reprint the Goodfriend article, which seems authoritative.

Dr. Schauffler's brochure contained the following sentence:

"People who have been in China as I was have seen eye to eye with George Marshall, Albert C. Wedemeyer, Owen Lattimore and dozens of others whose sound advices have been completely shelved for political expediency."

The apparent error of confusing Gen. Wedemeyer's views on Chinese Communists with those of Gen. Marshall, or of Owen Lattimore—the exponent of "agrarian reform"—may be relevant in assessing the soundness of Dr. Schauffler's own opinions on the subject.

WATSON WASHBURN.

Ed.

Attorney Washburn's letter was submitted to author Schauffler, who replied as follows:
To the Editor:

This is to acknowledge the copy of your letter from Mr. Watson Washburn which I have read with deep interest. Attorney Washburn's letter and the attitude which he represents certainly demand our serious attention. I must point out at once that the purpose of my China Chronicle was not to raise controversial issues. I wish to remind Attorney Washburn that the HARVARD MEDICAL ALUMNI BULLETIN is not a lay journal nor a legal forum. My intention was to give a factual report of what I had learned in China strictly in the medical field. Mr. Washburn is correct in pointing out that I strayed a bit from my original intention—tactlessly, no doubt. In any case, I am interested to know how the MEDICAL BULLETIN chanced into the hands of Attorney Washburn. His failure to sense my purpose reflects perhaps the legal rather than the scientific approach, and a penchant for Mr. Goodfriend and the propagandist-journalist technic of the Reader's Digest.

I don't propose in any sense to talk back to Mr. Washburn. I accept his scolding insofar as I may have blundered into any references to political or otherwise controversial matters. On the other hand, I cannot escape from an uneasy feeling engendered by Mr. Washburn's apparent attitude. Says he, "I was shocked to find the statement that the present outlook from the standpoint of public health and medical care is tremendously better than it has ever been in China." It might be that Mr. Washburn is chiefly concerned because he regards this statement as untrue, but since he says later, "I question the wisdom of publishing articles favoring any aspects of Communism," one is really induced to believe that Mr. Washburn is actually outraged over the fact that the prospects for the health of millions of Chinese may be improved. We doctors might feel that such an attitude would tend to weaken our intellectual approach. It may not be so with the legal mind. Mr. Washburn's attitude is so total in respect to political colors that one is tempted to wonder whether he must not shudder a bit at the traditional crimson of our Alma Mater.

The real purpose of this letter is to reassure

²Harvard Medical School, '13.

Mr. Washburn and others who have written me in similar vein. Actually, it now appears that the public health plans of the Communists in China are not working out nearly so well as we had hoped. The commentary which appeared in the Medical BULLETIN was completed for publication about seven months ago. Since that time, I have had further information which is, to me, exceedingly discouraging. I am compiling this material for early publication, but hesitate to bombard you again at so early a date. I would be obliged, however, if you would publish this letter, because I believe it may be a comfort to certain of your readers to know that the health picture in China is really not very good, even under the Reds.

GOODRICH C. SCHAUFFLER, '23

Ed.

All of this verbiage has been most gratifying to the Editor, who, like his predecessors, has felt that there was too little controversy in the pages of the BULLETIN.

However, one aspect of Attorney Washburn's letter requires comment, namely, the erroneous implication that "China Chronicle" was an article favoring any aspect of Communism. Dr. Schauffler's article was published as a first-hand account of one man's experience in helping to furnish medical care to postwar China. Evidence of corruption on the part of the Nationalist regime in the handling of medical supplies is not surprising and conforms to reports of many others on the Nationalist Government's activities. To interpret this data as favoring Communism would be comparable to calling Senator Fulbright a "Red" because he has questioned the morals of the R.F.C.

The statement that "the present outlook from the standpoint of public health and medical care is tremendously better than it has ever been in China" should be regarded as important and illuminating rather than "shocking." If the Communist regime did a better job of medical care than the Nationalist Government, that is news and we should know about it. Communists have always regarded health as more important than life. One can maintain a superb public health program and still execute thousands of political dissenters daily provided that the bodies are disposed of hygienically. This distinction appears to have escaped the legal mind of Attorney Washburn.

Actually it is well known that Communist regimes make a specific effort to gain a hold on a newly mastered populace by better distribution of food, medical supplies and clothing, so that Dr. Schauffler's reports are in keeping with our knowledge of the customary technic.

Finally the shadow which has fallen over China is so evident that the BULLETIN feels that there is no need to publish an article to this ef-

fect. And alas! it appears from Dr. Schauffler's latest report that the Chinese have not only lost their liberty, but all too soon they have lost their outlook for improved medical care and public health.

To the Editor:

It has been suggested that all physicians be urged to help alleviate the distressing financial status of the medical schools which find themselves with progressively larger annual deficits. It is hoped that funds contributed in this manner will either obviate or delay the ultimate control of the schools IF federal aid should be forthcoming. It is fair to assume that the majority of physicians making their contributions will do so with absolutely "no strings attached" other than the hope that a mixed committee would be invited to monitor the fair distribution of this aid to maintain the integrity of the schools.

We are anxious to have good medical schools to graduate good physicians to render good medical service to all the people. The Federal government seems to subscribe to this triple play BUT wishes to join the team through the back-door of political medicine. I offer then the idea, if it has not already been offered, that the government be asked to volunteer any sum it wishes to give NOT as an aid but as a contribution, coming as it were, from an alumnus, joining us all in this combined cooperative effort.

ARISTOCLES G. AUGUSTINE, '26

Ed.: Amen!

To the Alumni Office:

The Class of 1910, Harvard Medical School, at its Fortieth Reunion, voted to donate the balance of its fund, \$249.26, to the uses and benefit of the Alumni office itself. This action was prompted not only by the unfailing courtesy of the personnel of the office, but chiefly by the work they did and their valuable advice, both of which contributed largely to the success of the reunion.

It is our desire that this money be placed at the disposal of the Executive Secretary in charge of the office, that she may acquire or cause to have done, such things as may be deemed necessary or advisable, and which would not be possible under the regular budget.

HENRY C. MARBLE, *Treasurer*,

Class of 1910

To the Alumni Office:

It is my understanding that my Medical School class is setting about to raise a fund for presentation to the School on its 25th Reunion.

I am enclosing a check for \$250.00 to be credited to that fund.

This was obtained by an award I recently received from the American Academy of Pediatrics. I feel I owe this, and more if I get it, to the Harvard Medical School.

CHARLES D. MAY, '35.

Book Reviews

CLINICAL SONNETS. By Merrill Moore, M.D., 72 pages. New York, New York: Twayne Publishers, Inc., 1950. Price, \$2.50.

One of Merrill Moore's friends said, after he had read this book in manuscript form, "You must know a lot of very peculiar people!" Doctors *do* know a lot of very peculiar people, or perhaps all people, conventional to all appearances, reveal themselves as peculiarly individual when they tell about themselves to the doctor. Merrill Moore's peculiar people call to mind those whom Dr. Frederick C. Irving met on the Massachusetts General Hospital Accident floor: "Odd people with queer mental quirks and with strange employments."*

The following are some quotable passages. (For the sake of readability here, the sonnet lines are joined as prose.) "Unappreciative wives and husbands and children whose affections withdrew (if they ever existed)." "She got off the track of healthy feminine development at the age of seven." "Rude and obnoxious in the way he ate, and in the way he disposed of what he ate." "All his daily mind was at the keyhole of his flesh, his gonads and his endocrines. Unusually so, if I may mention it." "Each is a story, a pathological novel, an unwritten epic of frustration and despair." "He had patented an instrument for extracting comedones." "You could ask him any question and it was like hitting the jackpot on a gambling machine, the facts fell out so plentifully and fast." "She was a deep hole in which she lived, a kind of pixie, with a worm's eye view of everything, not my idea of a woman."

Merrill Moore finds a good deal of wonderment in the vast variety of personalities that parades in front of him and has found fit to set down his ideas in verse. This is effective. It

doesn't answer questions. It doesn't try to explain these personalities by psychiatric theory. As a matter of fact, it strikes the reviewer as a rather good way to write some types of psychiatric "scientific" articles, if one may be just a little facetious.

Merrill Moore has kindly designated a copy of this small book of sonnets to the library of the Alumni Office at the Medical School. Every one who is interested in Merrill Moore and his amazing sonnets, and every one should be interested in him, should drop in to read it.

CLARK W. HEATH, '26.

SIR WILLIAM OSLER, APHORISMS FROM HIS BEDSIDE TEACHINGS AND WRITINGS. Collected by Robert Bennett Bean, M.D.; Edited by William Bennett Bean, M.D. 159 pages. New York: Henry Schuman, Inc., 1950. Price, \$2.50.

This little book merits a place in the bedside library of every student of medicine, graduate or undergraduate. It is a collection of epigrams originally compiled by Dr. Robert Bennett Bean, the anatomist, who, while at the Johns Hopkins, jotted down the daily remarks and sayings of Sir William Osler on his teaching rounds. Dr. William Bennett Bean, Professor of Medicine at Iowa, has edited his father's notes and added selections from the published writings of the great physician. There is a delightful and informative foreword by John Fulton.

Broader in scope and more succinct than Camac's "Counsel and Ideals," these selections will serve a like purpose. They will freshen the memories and warm the hearts of those familiar with Osler's philosophy and for the uninitiated they will open the door to a joyous and rewarding exploration of his writings and addresses in the original.

Those who possess this volume may, in the words of Sir William himself, "Spend the last half-hour of the day in communion with the saints of humanity."

J. E. D.

*Safe Deliverance, by Frederick C. Irving, Houghton Mifflin Co., Boston, 1942.



